COLANGIOPANCREATOGRAFIA RETROGRADA ENDOSCOPICA

INFEZIONE

Luca De Luca

S.O.C. Gastroenterologia ed Endoscopia Digestiva

A.O. Ospedali Riuniti Marche Nord

PESARO

T.B. uomo 62 anni

Diagnosi di Ammissione

- Ittero ostruttivo

Laboratorio

- CEA, CA 19-9, α-FP negativi

Anamnesi Patologica Remota

- Colecistectomia
- Pancreatite acuta biliare
- Insufficienza renale cronica

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ECOGRAFIA ADDOME SUPERIORE

Fegato di volume aumentato, ad ecostruttura diffusamente iperecogena ed addensata - Asse portale di calibro pari a 12 mm - Esiti di colecistectomia - Marcata dilatazione delle VBI con presenza di spots ecogeni nel coledoco riferibili a sludge

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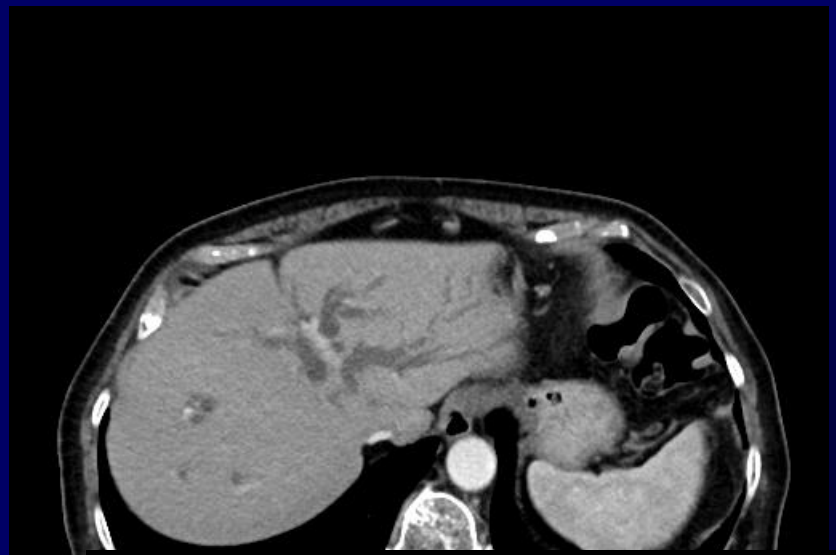
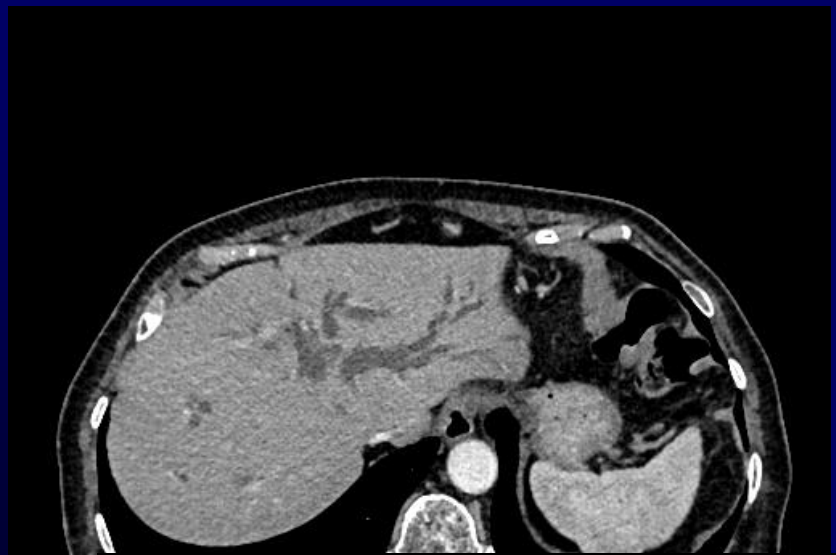
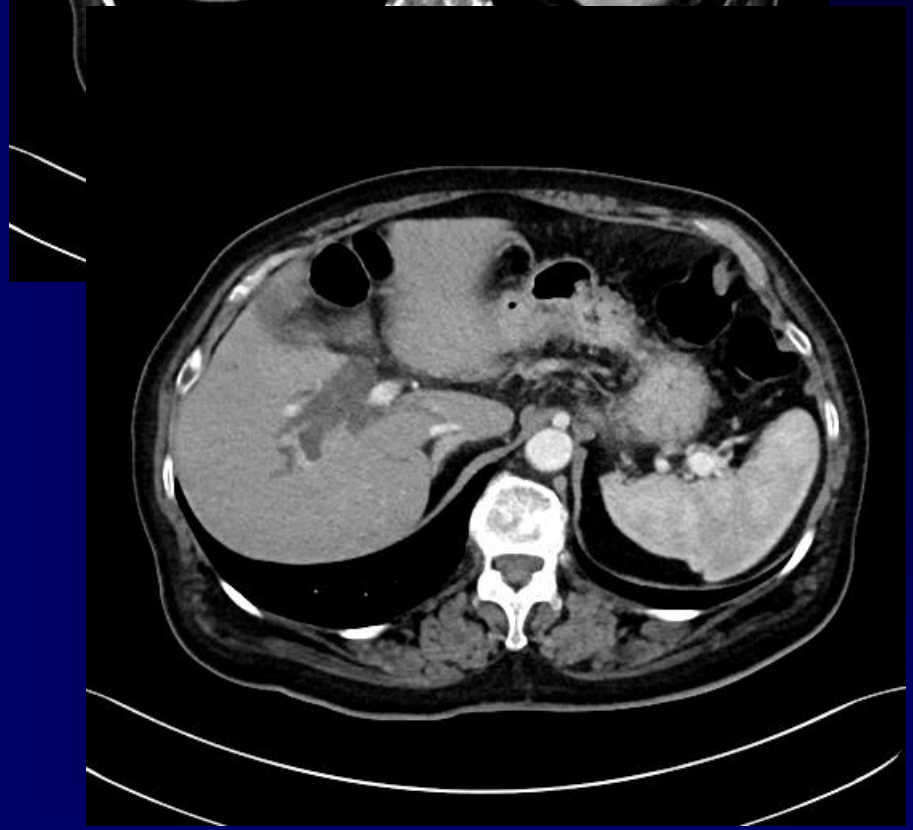
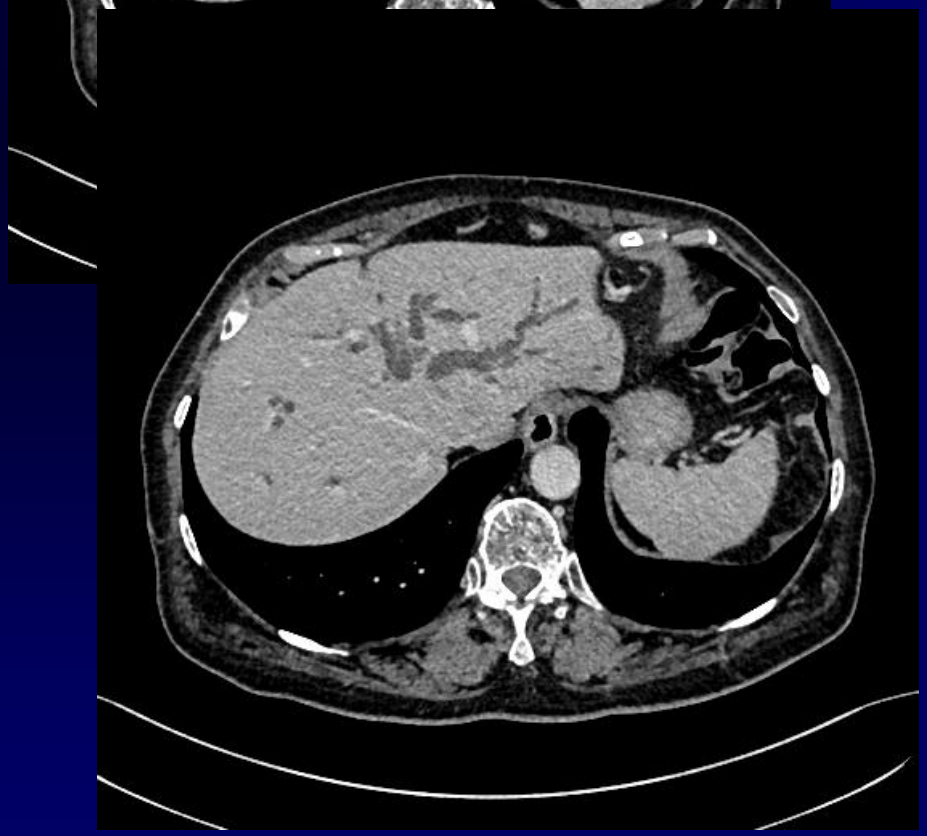

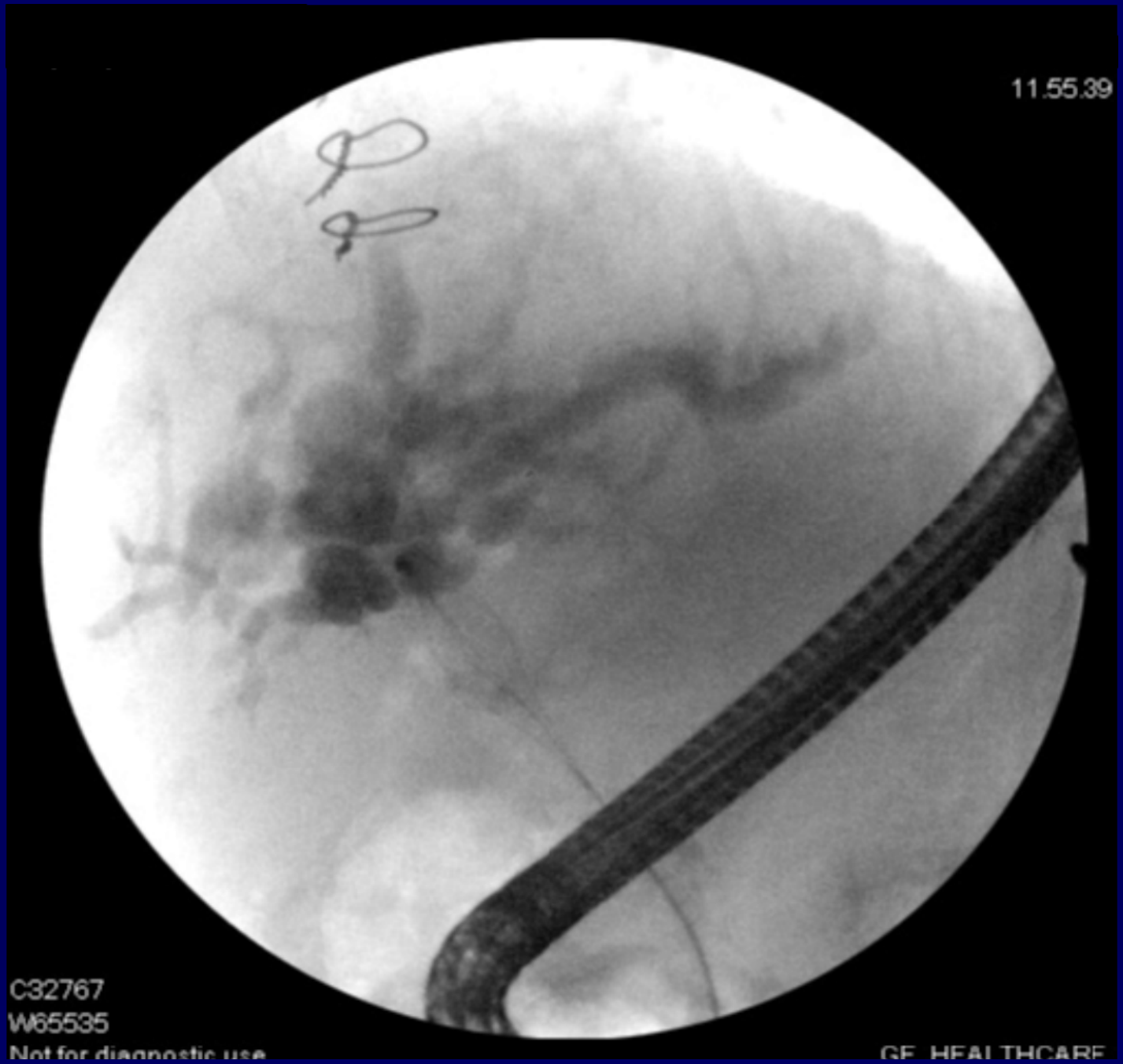
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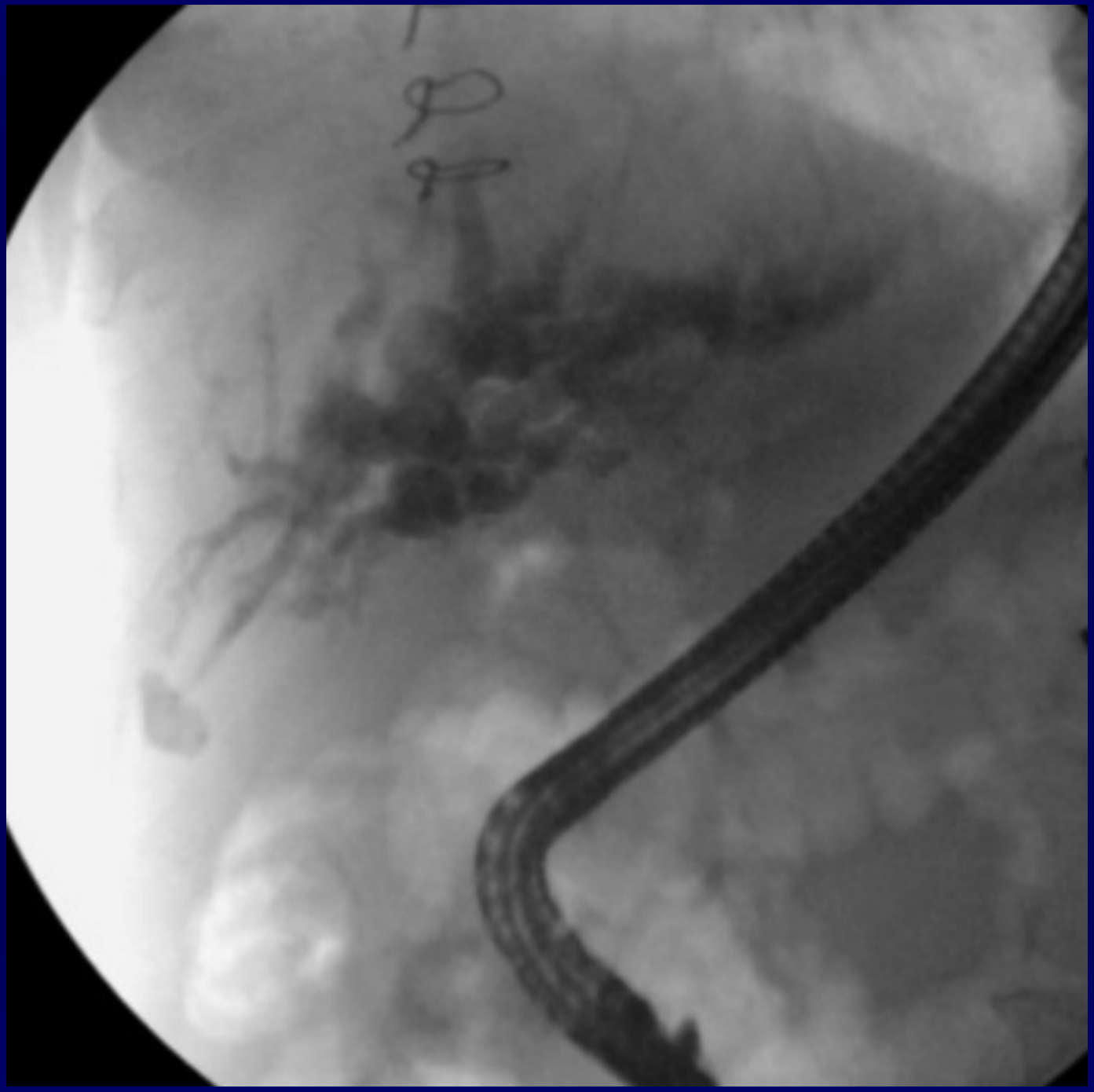

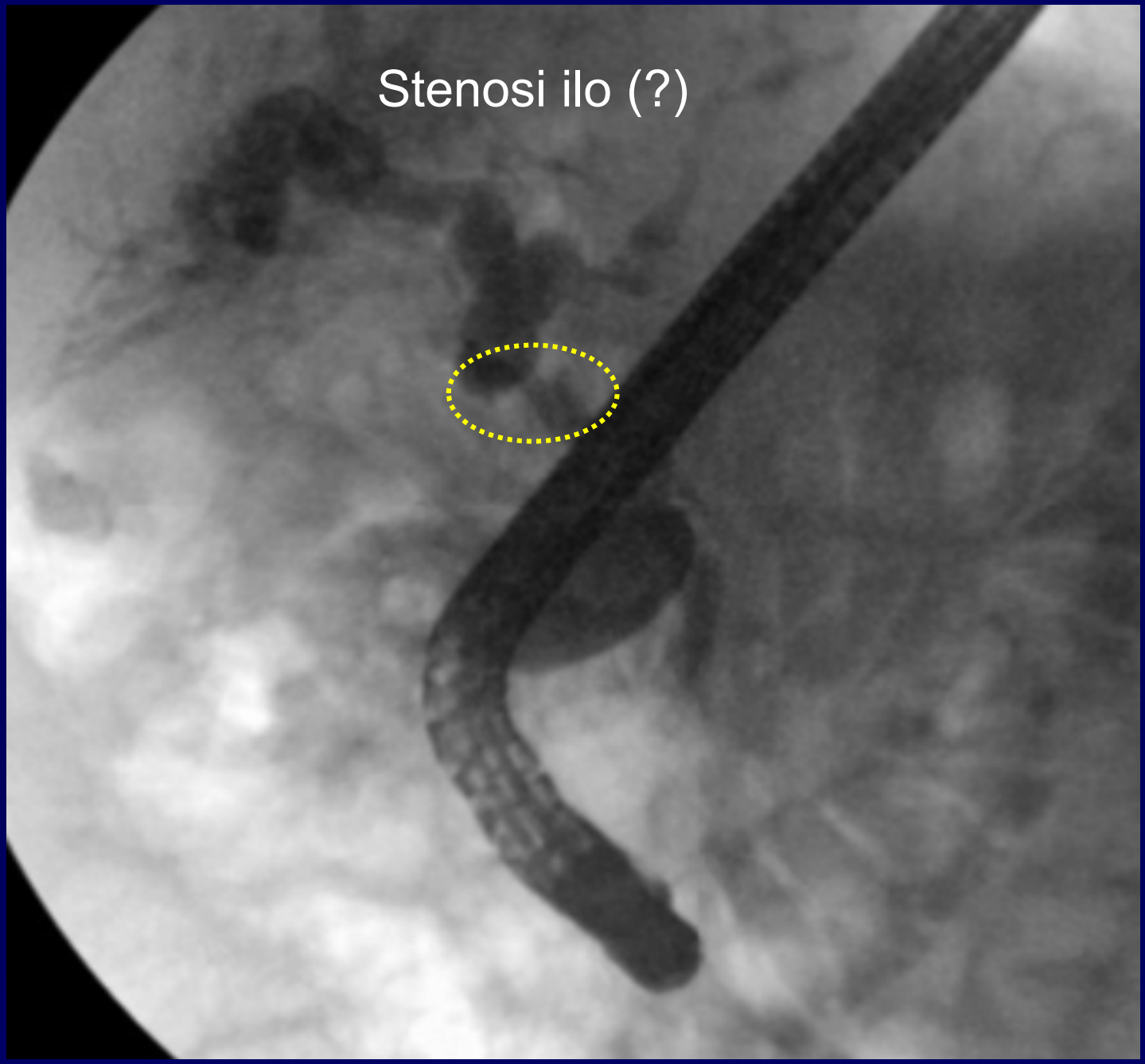
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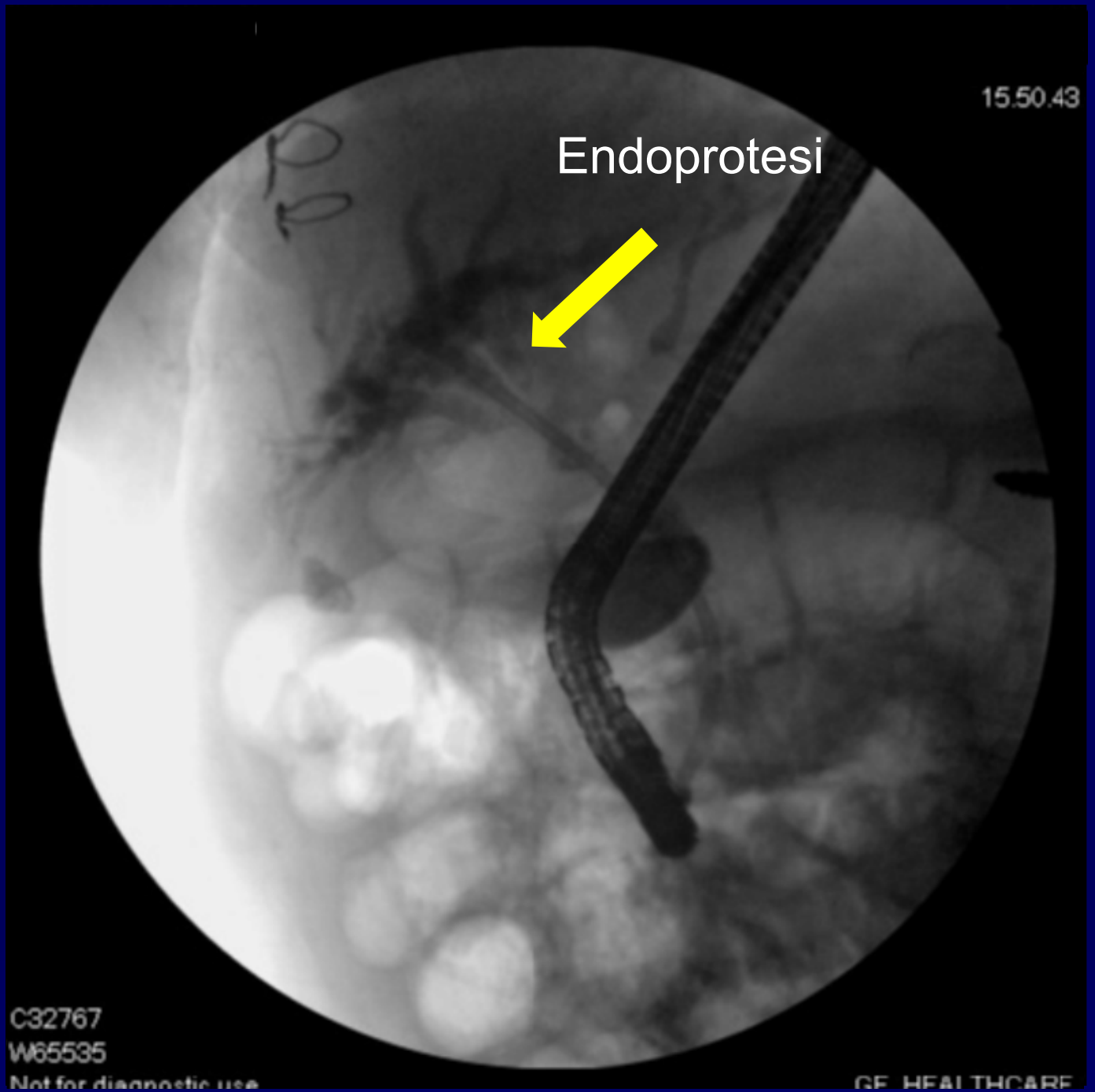
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GE HEALTHCARE

….dopo 1 settimana

COLANGITE

Acute cholangitis: Clinical manifestations, diagnosis, and management

Author: Nezam H Afdhal, MD, FRCPI
Section Editors: Sanjiv Chopra, MD, MACP, Stephen B Calderwood, MD
Deputy Editor: Shilpa Grover, MD, MPH, AGAF

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: **Jul 2019.** | This topic last updated: **May 28, 2019.**

Empiric antibiotic regimens for high-risk community-acquired intra-abdominal infections in adults

	Dose
Single-agent regimen	
Imipenem-cilastatin	500 mg IV every six hours
Meropenem	1 g IV every eight hours
Doripenem	500 mg IV every eight hours
Piperacillin-tazobactam	4.5 g IV every six hours
Combination regimen with metronidazole	
ONE of the following:	
Cefepime	2 g IV every eight hours
OR	
Ceftazidime	2 g IV every eight hours
PLUS:	
Metronidazole	500 mg IV or PO every eight hours

Adverse events associated with ERCP

Prepared by: ASGE STANDARDS OF PRACTICE COMMITTEE

COLANGITE

- Incidenza fino al 3% dei casi
- Mortalità fino al 10% (con trattamento) e del 30-50% (senza trattamento)
- Diagnosi precoce → outcome migliore → prognosi favorevole

IDENTIFICAZIONE

STRATIFICAZIONE

→ *Timing ERCP*

ASGE Guidelines. Gastrointest Endosc 2017; 85(1):32-47

RECOMMENDATION

ESGE recommends using the 2018 revision of the Tokyo Guidelines to classify the severity of acute cholangitis. Strong recommendation, low quality evidence.

The 2013 revision of the Tokyo Guidelines [221], recently confirmed by the 2018 revision [222], classifies acute cholangitis as:

- severe, dysfunction of at least one of the following systems: cardiovascular, neurological, respiratory, renal, hepatic, or hematological system (specific criteria are stated for each item)
- moderate, any of the following: white blood cell count >12 000 or <4000 /mm^3, fever ≥39 °C, age ≥75 years, total bilirubin ≥5 mg/dL, or hypoalbuminemia
- mild, no criteria of moderate/severe cholangitis.

RECOMMENDATION

ESGE recommends the following timing for biliary drainage, preferably endoscopic, in patients with acute cholangitis, classified according to the 2018 Tokyo Guidelines:

- severe, as soon as possible and within 12 hours for patients with septic shock
- moderate, within 48 – 72 hours
- mild, elective.

Strong recommendation, low quality evidence.

The TG13 severity grading criteria are recommended to be used as the TG18 criteria because patients whose prognosis can potentially be improved by early biliary drainage can be identified by using these criteria. (Recommendation 1, level D)

ESGE Guideline 2019. Endoscopy 2019; 51(5):472-91

Tokyo Guideline 2018. J Hepatobiliary Pancreat Sci 2018; 25:17-30

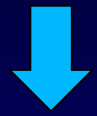
Definitions, pathophysiology, and epidemiology of acute cholangitis and cholecystitis: Tokyo Guidelines

Ipertensione vie biliari e ristagno m.d.c

Aumento permeabilità dei duttuli biliari

Traslocazione batteri e endotosisine

("reflusso colangio-venoso")



Aumento rischio setticemia

Kimura Y et al. J Hepatobiliary Pancreat Sci 2007; 14:15–26

Fattori di rischio

- **Drenaggio incompleto**

- **Re**

- Pregresso st

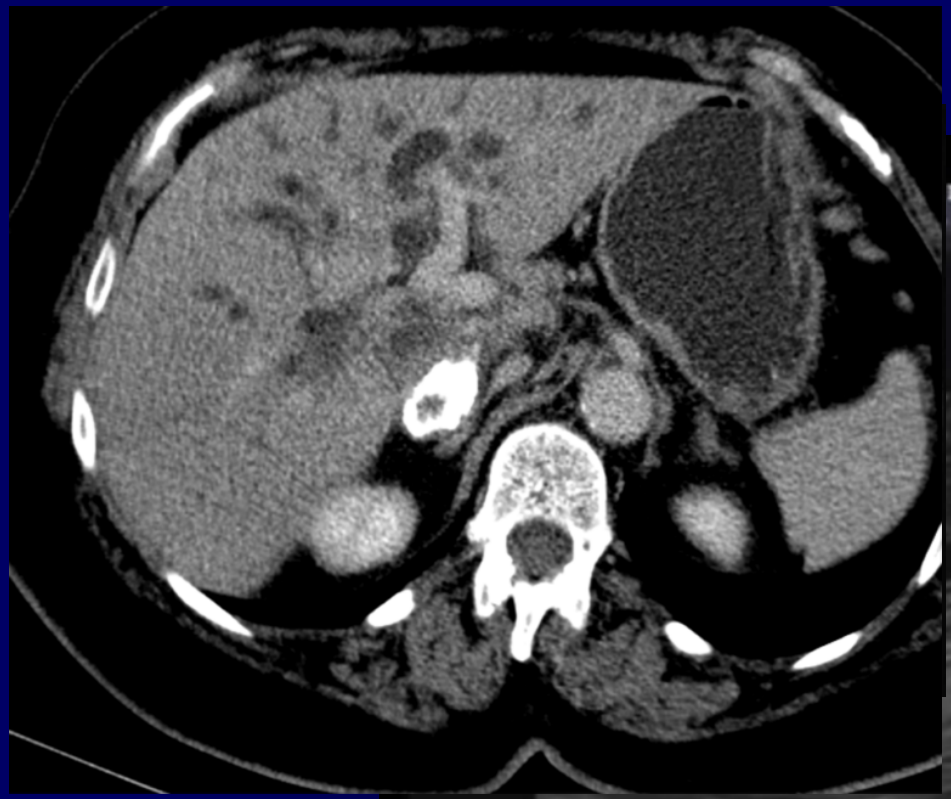
- Inappropriat

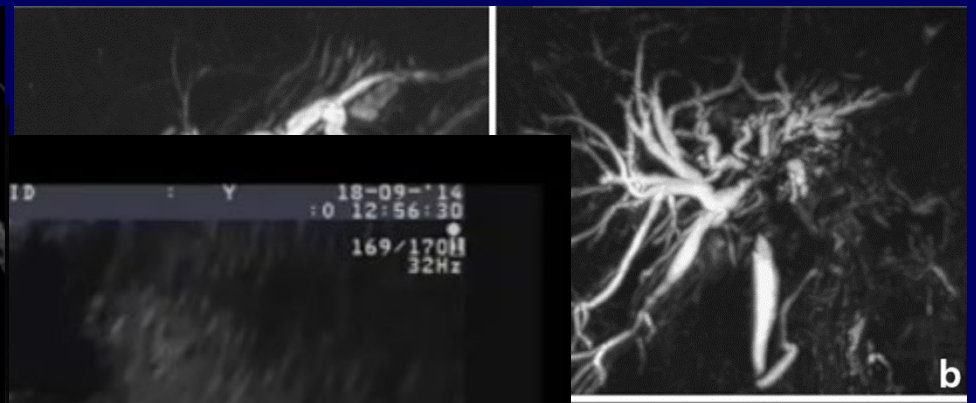
- Trapianto di f

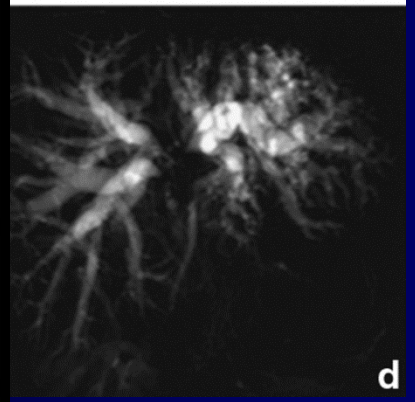
- Mancata prof c.)

- Caratteristich

ASGE Guidelines. Gastrointest Endosc 2015; 81(1):81-89







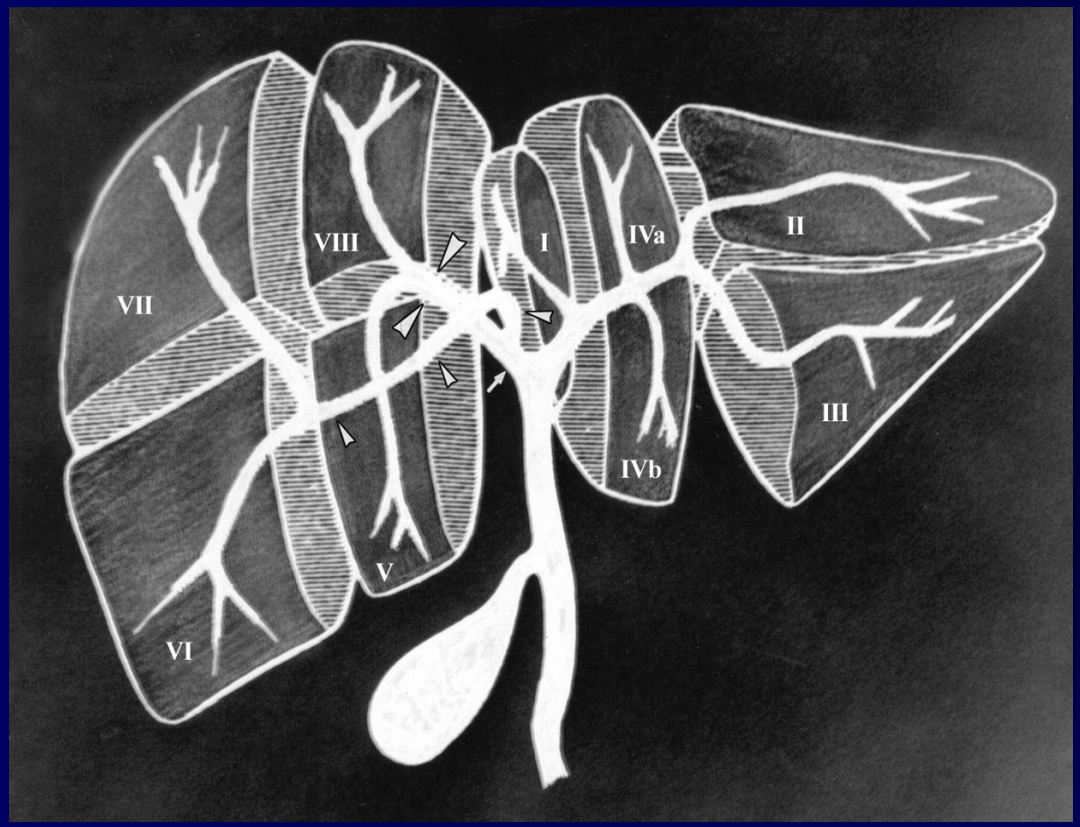
1. staging
2. parenchima epatico residuo

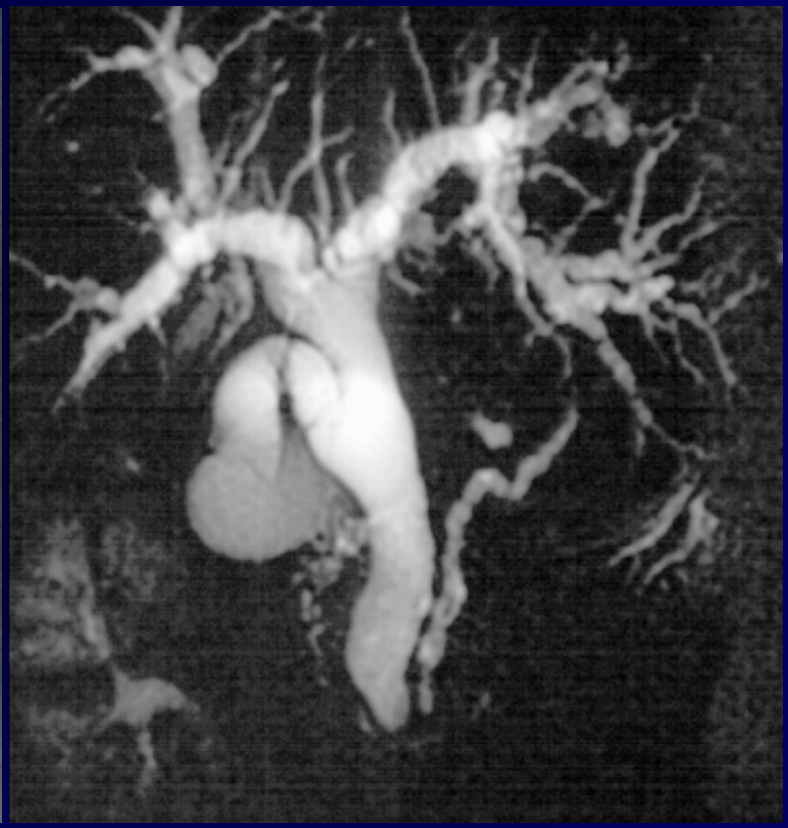
stenosi ilare

2. fattibilità
3. quali e quanti settori drenare

Imaging pre-operatorio

ANATOMIA DELLE VIE BILIARI





Varianti Anatomiche

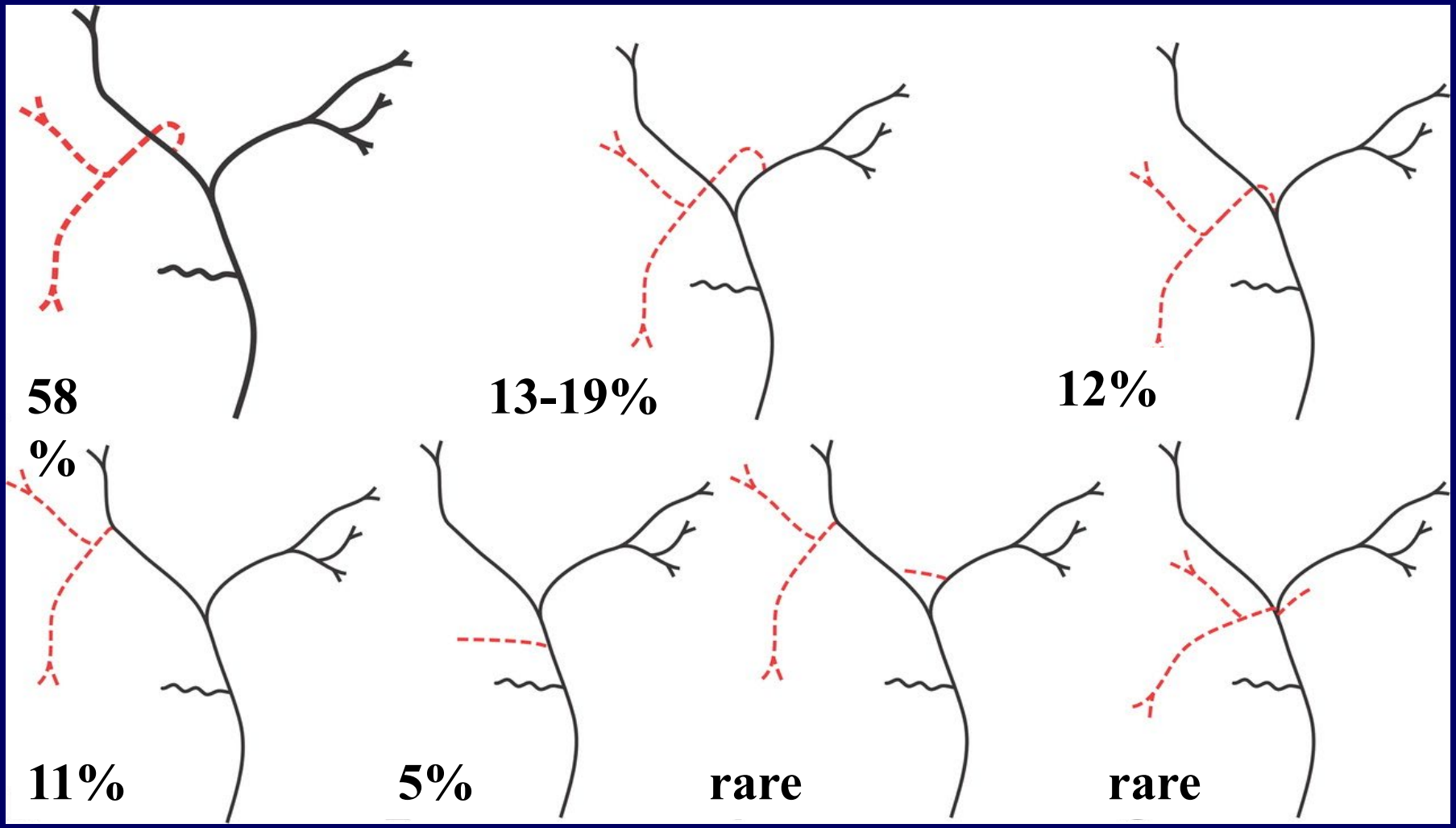


TABLE 3. Antibiotic prophylaxis and/or treatment to prevent local infections

Patient condition	Procedure contemplated	Goal of prophylaxis	Periprocedural antibiotic prophylaxis
Bile duct obstruction in absence of cholangitis	ERCP with complete drainage	Prevention of cholangitis	Not recommended ⊕⊕⊕⊕
Bile duct obstruction in absence of cholangitis	ERCP with incomplete drainage	Prevention of cholangitis	Recommended; continue antibiotics after procedure ⊕⊕⊕◯

3. We recommend against antibiotic prophylaxis before ERCP when obstructive biliary tract disease is not suspected or complete biliary drainage is anticipated. (⊕⊕⊕⊕)
4. We recommend that antibiotic prophylaxis be administered before ERCP in patients who have had liver transplantation or who have known or suspected biliary obstruction, where there is a possibility of incomplete biliary drainage. Antibiotics that cover biliary flora such as enteric gram-negative organisms and enterococci should be used and continued after the procedure if biliary drainage is incomplete. (⊕⊕⊕◯)

ASGE Guidelines. Gastrointest Endosc 2015; 81(1):81-89

Profilassi

Istruzioni operative